February 15, 2001

Dear Dr. Trujillo:

We are pleased to present to you a recommended CHS distribution methodology for your consideration and, if acceptable, for presentation to the Tribal Leaders National Consultation meeting in March. We extend our appreciation for your leadership and support for the workgroup and assistance in this consensus-building process. Your comments and words of encouragement in our meeting in San Diego, California, are appreciated and have indeed given us the needed direction in completing this important charge.

The CHS Allocation Work Group and the Technical Sub-Work Group have worked extensively in the short time that they have collaborated through a consensus building process. There was extensive discussion concerning this resource allocation methodology which should not be considered as a tool for budget projections to meet the health needs of the Indian population. It was determined that as an allocation methodology, the use of a health status indicator was not as critical as if used in a budget projection tool focused on particular health needs.

The input and contributions made by each member have been invaluable. Throughout the development process the Work Group members continually demonstrated a focus on services and dedication in meeting the health care needs of all American Indian and Alaska Natives. Many issues and concerns that impact CHS were discussed. However, there are still some matters that were not resolved simply because of limited time and data resources. The Work Group has made recommendations for future review and these are contained in the report. This process has indeed opened our eyes and caused us to realize that there is still a great deal of work to be done by the IHS and Tribal leadership.

We appreciate your comment, “This is not the end but a beginning in building a future process.” Again, thank you for your support. We are proud to have been a part of this process. We believe we are providing you with a CHS distribution methodology that is both acceptable and workable.

Sincerely yours,

Vern Donnell
IHS Co-Chair
CHS Allocation Work Group

Lydia Hubbard-Pourier
Tribal Co-Chair
CHS Allocation Work Group

Recommended
FY 2001 Contract Health Service (CHS) Formula

Introduction

Contract Health Services (CHS) is a line item in the Indian Health Service (IHS) budget intended for purchasing health care services from the private sector for eligible beneficiaries. Use of CHS funding is governed by special regulations that are more restrictive than other IHS services. For example, CHS can only be used for eligible beneficiaries who live in a Contract Health Service Delivery Area (CHSDA) and alternate resources must be used first. Prior authorization is required for all referred care and emergency services must be reported within 72 hours. Historically, CHS funding has been so limited that a priority system has been developed to ration CHS resources.

In some cases, CHS is used to contract for services that are delivered in an Indian health facility. For example, it may be more cost effective to contract for a physician in private practice to hold a cardiac clinic in an IHS facility once a week, rather than referring patients to a cardiologist for appointments at the physician's office. Therefore, the distinction between the CHS and Hospitals and Clinics (H&C) line items is often blurred. Tribes that have P.L. 93-638 contracts and self-governance compacts have the authority to reprogram funds between line items in order to meet their service requirements.

There is a wide range of dependency on CHS as part of the overall personal medical services provided through the IHS. In most places, CHS is used to augment services that are provided by the IHS and/or tribes. For example, CHS is typically used to procure specialized medical services beyond the scope of the IHS/Tribal (I/T) services, such as cancer treatment. American Indians/Alaska Natives (AI/AN) rely on CHS for all of their inpatient care in the California and Portland Areas, and for nearly all their inpatient care in the Bemidji and Nashville Areas. Newly-recognized tribes currently receive all of their initial funding through the CHS line item. Some tribes rely exclusively on CHS and do not operate any outpatient or inpatient services. In a few cases, IHS funding is used to purchase a managed care plan for tribal members.

Over the years, various formulas have been used to distribute CHS funds. In response to tribal requests, Dr. Michael Trujillo, Director of the IHS, formed a CHS Work Group to solicit tribal input and recommend how the new CHS funds should be distributed. ***(See Appendix A***) This paper summarizes those recommendations from the Work Group to Dr. Trujillo and are subject to further tribal consultation and comment.

Process for Developing Recommendations

The CHS Work Group (WG) developed the following basic design principles:

- The formula should be designed based on principles rather than showing the results of the formula first.
- Common factors will be applied across the IHS and tribal programs.
- While scarce resources mean that unmet needs exist at all CHS locations, the challenge is to describe the CHS need from one program to another.
- The CHS formula should be rational, reasonable, defensible, manageable, fair and equitable.
- Population size should be considered in the CHS distribution formula.
- Growth factors should be considered.
- Total dependence on CHS for ambulatory and inpatient services should be considered.
- The most current and complete data should be used, in most cases current or prior fiscal year only.
- The simplest data driven formula possible should be used.
- The formula will have multiple factors.
- The formula should maintain buying power and be inflation proof to the extent possible.
- The formula should incorporate differences in health care costs at the point of service.
- CHS funding for new tribes should come from new CHS appropriations, and non-CHS funding for new tribes should not come out of the CHS appropriations.

A Technical Work Group (TWG) was formed to consider the availability of data and to develop approaches that would meet the criteria set forth by the WG. The TWG evaluated six different options using the above criteria. These options included:

1. Distribute CHS "Program Increase" using the "Percentage of Historical Base" method.
2. Distribute the new funds using the same allocation formula as last year.

3. Distribute using a direct allocation to the operating units in greatest need of CHS resources.

4. Distribute the new funds using the same allocation as last year, except revising or "tweaking" the three variables.
(Workload, Health Status, and CHS Dependency).

5. Distribute based on a mixture of historical and a new formula.

6. Distribute on a whole new formula using cost and demand for services.

When the options were evaluated using the principles developed by the WG, Option 5 was selected as the approach that was most responsive to the direction provided by the WG. This option was further developed by designing a conceptual framework, identifying possible data elements, and selecting and combining the data elements into a formula.

Background Information Regarding the Old Formula

The FY 2000 CHS distribution formula was made up of three components, and a percentage of the appropriated funding was allotted to each component as follows:

	Relative Weight	FY 2000 Allotment
a) Workload/Cost	20%	$2,632,000
b) Years of Productive Life Lost (YPLL)	40%	$5,264,000
c) CHS dependency	40%	$5,264,000

Workload/Cost

The Workload/Cost component accounted for the volume of CHS services produced within each IHS Area. Services counted included dental, outpatient, inpatient, and patient/escort travel costs. The volume of services produced in each of the first three categories was taken from numbers reported to the IHS, multiplied by an average cost calculated from IHS fiscal intermediary data. Patient & Escort travel was based on actual reported costs.

The total values for each of the four sub-categories were added together, and then multiplied by a cost index factor based on the HCFA wage index for each IHS Area. The adjusted cost for each IHS Area was compared to the actual recurring base for each Area to determine a shortfall amount for each Area. These shortfall amounts were added together, and a proportional percentage of the total shortfall was assigned to each Area as the amount to be received from the funds available for distribution under the Workload/Cost component of the formula.

This approach was found to be problematic because:

- Workload was limited by available funding, which is not a good measure of CHS need.
- Data was incomplete, due to utilization data from the Fiscal Intermediary (FI) only. Many tribes do not use the FI.

Years of Productive Life Lost (YPLL)

The YPLL component of the formula calculated a value of excess years of productive life lost for each IHS area in relation to the U.S. rate. Funding available for this component was allotted based on a proportional percentage of the total excess YPLL for each Area.

This approach was found to be problematic because:

- It does not relate to the cost of treating illness, but rather reflects the cost of disease to society in terms of lost wages and taxes.
- It assigns much greater weight to disease that occurs in youth, which does not actually cost CHS more to treat than disease that occurs in elders.
- It relies on death statistics that are not accurate for AI/AN in some states.

CHS Dependency

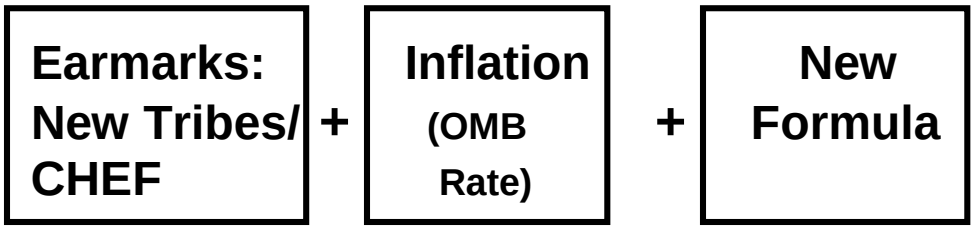
Inpatient admissions were used to calculate dependency for each Area, the number of CHS inpatient admissions was divided by the total admissions (CHS and IHS). The IHS average percentage for CHS dependency was 23.9%. The five Areas below this average did not receive any allocation for this component of the formula. A proportional amount of the total above the average was recalculated and allotted to the remaining seven Areas.

This approach was found to problematic because:

- The dependency factor in no way related to the population to be served. For example, certain Areas having large inpatient CHS workloads received none of this funding.
- It did not recognize that all Areas have some degree of dependency on CHS.
- It relied on a distorted scale that had only limited validity in describing the differences in scope of CHS services. Using this approach, the amount allotted per admission was $1,826 in one Area and $42 in another Area. Five Areas had $0 per admission.
- The data became distorted when applied to an Operating Unit (OU) level.

Overview of the Recommended Distribution Plan

The FY2001 budget for the IHS provides an increase of $40 million in the CHS line item. The new CHS funding is divided into three parts: I. Congressional earmarks, II. Inflation funding; and III. New formula. . ***(See Appendix B)***



The mandatory funding for CHEF, Ketchikan Indian Corporation (KIC), and new tribes is specified in legislative intent. These funds should be determined first and the remaining amount will be available for inflation funding and the new formula. The WG recommends that IHS reserve the minimum amount necessary to meet the needs for new tribes. If too much funding is reserved for new tribes, the excess will be distributed at the end of the year using the new formula. However, there is a general consensus that allocation of CHS funding is desperately needed as soon as possible.

For FY 2001, it is estimated that about $4.1 million will be needed for CHEF, KIC and new tribes. That leaves about $35.8 million for distribution using inflation adjustment and the new formula. The division in funding between inflation adjustments and the new formula presents several challenges:

- Inflation funding preserves the historic base, which some Areas believe is not equitable. The more that is allocated for inflation, the less that is available for the new formula, which is presumed to be more equitable.

- The $40 million in new funding for CHS in FY2001 is sufficient to allocate funding for both the recommended inflation adjustment and the new formula. However, if new CHS funding is less and/or the inflation rate increases in future years, the entire amount may be absorbed by the inflation adjustment. In that event, there would be no funding available for the new formula unless inflation funding was constrained to a specific portion of the available funding.

The WG could not agree on a percentage distribution of the inflation adjustments and the new formula. The WG recommendation is to fully fund the inflation adjustment at the OMB medical inflation rate and to use the remaining amount for the new formula for FY2001. The WG further recommends that allocation percentages be reconsidered in FY2002 ***(See Appendix C)***

The new formula has three basic factors that are multiplied together: (a) user population; (b) relative cost of purchasing services; and (c) access to care. The result of this computation is a number that is used to calculate the proportion of the allocation that goes to each operating unit.

New Formula:

Operating Units

The WG recommends that calculations be made at the operating unit (OU) level, as defined in the Level of Need Funded (LNF) methodology. However, funding for all operating units in an Area are also added together to determine the Area funding level which would include funding for medical centers, which may not be recognized as OUs. In consultation with tribes, Areas may decide to redistribute funds using a different approach.

Now that we have presented an overview of the recommended distribution plan, we will provide more details about each part of the formula. ***(See Appendix D)***

I. Congressional Earmarks

Legislative report language for FY 2001 earmarks a portion of the new CHS funding for CHEF, Ketchikan Indian Corporation and unfunded tribes[1].

Catastrophic Health Emergency Fund (CHEF)

In the 2001 Interior Appropriations Conference Report 106-914, September 29, 2000, the following language appears:

> Language is included raising the amount for the Catastrophic Health Emergency Fund from $12,000,000 to $15,000,000 ...

Therefore, $3 million of the new funding is reserved for CHEF.

[1] Unfunded tribes include restored/reinstated tribes, newly federally recognized tribes and existing federally recognized tribes that did not previously receive funds.

Ketchikan Indian Corporation (KIC)

In the 2001 Interior Appropriations Conference Report 106-914, September 29, 2000, the following language appears with regard to KIC:

> *Within the funding provided for contract health services, the Indian Health Service should allocate an increase to the Ketchikan Indian Corporation (KIC) recurring budget for hospital-related services for patients of KIC and the Organized Village of Saxman (OVS) to help implement the agreement reached by the Indian Health Service, KIC, OVS and the Southeast Alaska Regional Health Corporation on September 12, 2000. The additional funding will enable KIC to purchase additional related services at the local Ketchikan General Hospital. The managers remain concerned that the viability of Alaska Native regional entities must be preserved. The accommodation by the managers of the September 12, 2000 agreement in no way is intended to imply that similar requests for similar arrangements will be encouraged or supported elsewhere in Alaska.*

The agreement referenced in the above language commits $140,000 from CHS funds.

Unfunded Tribes

Recent IHS policy has been to request funding for newly-recognized tribes from the Contract Health Services fund. This approach was taken for several reasons; one being that a newly-recognized tribe would not likely have access to an IHS facility from which to receive health services, but would be required to purchase health care. It appears that this approach also may have been beneficial in order for the agency to retain the funding availability should the tribe not commence services in the year in which funds were appropriated. There was a concern that if funding were requested in another category of the IHS budget, those funds appropriated would not retain their availability beyond one year.

Senate Report 106-312 stated, “The Committee notes that within the contract health services activity, funds will be available to the Cowlitz Tribe for the provision of health care, if the tribe is recognized within the coming year.” There was no language in the Appropriations Act itself regarding funding newly-recognized tribes in FY 2001.

Recommendations for Unfunded Tribes

1. Estimate for unfunded tribes should be reserved from the FY 2001 CHS appropriation increases to the IHS. Although the report language of the Senate does not carry the force of law, it does express the understanding of the Congress and the terms under which the increases were appropriated to the IHS for FY 2001.

In order for the agency to act within the probable intent of the Congress, it is recommended that CHS increases be utilized to fund tribes that commence health services in FY 2001.

2. The process for requesting budgetary needs for unfunded tribes for FY 2002 and forward should be changed. Justifying unfunded tribal needs along with the funding needs of existing CHS programs is not congruent and confuses the purposes for the increase. Resources for unfunded tribes should be approached in a manner similar to that of inflationary, pay cost and other "uncontrollable" increases to the budget and addressed as a separate line item. The language accompanying the unfunded tribes budget request should provide for "no year" or similar designation, and that such funds may be reprogrammed to the appropriate sub-sub activity(ies) of the IHS once the tribe becomes active in the system. In its meeting of January 18, 2001, the CHS Work Group was informed by a representative of IHS Headquarters that a different method of pursuing appropriations for unfunded tribes would be employed for FY 2002.

3. The process for estimating amounts for unfunded tribes requires revision. For FY 2001, the planning figure utilized by IHS Headquarters for unfunded tribes was approximately $7 million, which could be "set aside" from the appropriation increase of $40 million. Since this set aside affects the amount of new CHS funds to be distributed to existing programs, the CHS Work Group believes it necessary to make recommendations regarding the process for determining planning estimates that are used for this purpose. The Work Group received information from the IHS Office of Tribal Programs (OTP) regarding the existing process to provide resources to unfunded tribes. Based on this information, the Work Group makes the following recommendations regarding any "set aside" of funds from CHS in FY 2001, as well as the process for developing these estimations in general:

   A. *The prior estimate of $7 million should be revised to be more realistic.* Due to information that the OTP now has concerning the recognition status of several tribes and the requisite appellate processes, it is anticipated that the tribes that may be funded for the first time in FY 2001 are:

	IHS Estimated Funding
➢ Cayuga Nation (Nashville	$426,813
➢ Onondaga Nation (Nashville):	$1,350,675
➢ Graton Rancheria (California):	$331,931
➢ Kodiak (Alaska):	no estimated amount
➢ King Salmon (Alaska):	no estimated amount
➢ Lower Lake Rancheria (California):	no estimated amount
➢ Loyal Shawnee (Oklahoma)	no estimated amount
TOTAL:	$2,109,419

The population numbers and per capita costs for the Kodiak, King Salmon, Lower Lake Rancheria and Loyal Shawnee tribes are unknown at this time, and a projected dollar amount has not been estimated by OTP.

B. *The planning estimate for unfunded tribes should utilize an estimated user population, rather than tribal enrollment.* All existing tribes must use user population in distribution of funding. User population is generally substantially lower than tribal enrollment. For consistency in funding, it is more appropriate to use a projected user population for the first year, which may be adjusted in 1-2 years once an actual count is known. To achieve such an estimate, the IHS may use a national or Area ratio of user population to total tribal enrollment, applied to the tribe's enrollment.

C. *Any resources for unfunded tribes made available from CHS appropriations should not include Area/HQ residual funds.* Currently, funds are reserved from CHS for IHS residual funds for these tribes. It was noted by some Area representatives that CHS funding may not be used for residual purposes. In addition, it is inadvisable to utilize CHS funds for residual, in order to justify further increases to the Congress.

D. *Resources for unfunded tribes should not duplicate existing IHS services.* It was determined by the Work Group that many of the unfunded tribes being monitored by OTP were currently being served by the IHS, and had user population numbers already in the system. When OTP estimates a population for purposes of new funding, it does not account for services already being provided in the IHS system. The Work Group recommends that any existing user population of an unfunded tribe be considered in estimating the new funding required.

E. *Resources for unfunded tribes should be accurately prorated to reflect the actual period that the funding is to cover*. In practice, allocation to new tribes is often delayed and funding is not needed to cover the entire year. The Work Group felt the IHS should accurately pro rate the new funding to cover the actual period needed from approval of a new tribe to the end of the fiscal year.

Given the issues above, the CHS WG recommends that only $1 million be set aside at this time for unfunded tribes, with up to an additional $1 million distributed to OUs non-recurring in FY 2001 to be utilized for annualized funding in future years, should it become necessary.

4. Any reserved resources for unfunded tribes not expended should be redistributed according to the new CHS formula. The IHS should establish a reasonable "cut-off" date to redistribute unused funds on a recurring basis. This redistribution of resources reserved for unfunded tribes should be implemented with sufficient time for tribal and IHS programs to put the funds to good use.

II. Inflation Funding

Inflation has consistently eroded the purchasing power of CHS funds for all IHS and tribal programs over the past decade. This problem has been particularly acute for the CHS program as medical inflation rates in the early part of the decade were rising 2 to 3 times faster than the increases provided by Congress to the CHS program.

Several different inflation rates were considered and it was acknowledged that there may be regional variations in the medical inflation rate. Although the OMB medical inflation rate usually understates the true rate of inflation of medical costs, the WG recommends using the OMB medical inflation rate in the formula for the following reasons:

- This rate was approved by OMB for the federal budget so it has legitimacy for the administration and Congress. If Congress had funded inflation for CHS as a specified line item, this is the rate they would have used.

- This rate is more consistent with the rate the IHS uses for the Hospitals and Clinics portion of the budget, so inflationary increases will be reasonably consistent across CHS and directly operated programs

The OMB medical inflation rate for the FY2001 budget is 3.9 percent. This is multiplied by the FY2000 OU base budget for CHS of $389,922,579 for a total of $15,206,981 to be distributed for this portion of the allocation. This leaves about $20.5 million to be distributed using the new formula.

The Work Group also discussed at length whether the amount of funding for inflationary costs should be capped at some portion of the overall appropriation. Although the Work Group did not recommend this cap for the FY2001 distribution, it did recommend that this issue be revisited in subsequent years. The importance of this cap is directly related to the size of the future year appropriations. To the extent that these appropriations fall below the OMB approved medical inflation rate, there may be no funds left to distribute using the second portion of the formula if there is no cap.

III. New Funding Formula

The new funding formula starts with active user population. This number will be adjusted by multiplying by two modifying factors. The first factor will be a cost adjustment factor derived from the American Chamber of Commerce Researchers Association (ACCRA) cost of living index[2] which provides regional comparative costs for dental, doctor visits and hospital days. The second factor provides an additional upward adjustment for operating units that do not have access to a IHS or tribal hospital.

Active Users

A basic assumption is made that as more people are served, more funding is needed for CHS. The formula is to be based on the number of active users that reside in a CHSDA in the operating unit. The data are to be the most recent available from the IHS data system when the distribution is made.

Cost Adjustment Factor

The Work Group recognizes that it cost more to purchase medical care in some parts of the country than in other places. Thus, the formula recognizes the relative cost of purchasing care in different geographic areas of the country. The formula takes into account the relative costs of inpatient care and outpatient care. Several indices were considered, including the composite cost index utilized by LNF formula and the ACCRA Regional Cost of Living Index published by the ACCRA. The Work Group selected the ACCRA index because it is independently maintained and because it has costs of care for physician visits and hospital day for over 317 geographic areas.

The cost adjustment factor is a composite of the relative costs of a doctor visit and hospital day. Each factor will be weighted by the relative proportion of this type of service that is purchased by CHS funds nationally using FI data from FY 1999. This weighting is:

Inpatient	65%
Outpatient	35%
	100%

There was active discussion in the Work Group regarding the inclusion of travel and dental in the cost adjustment category. However, both the inpatient and outpatient service represent the major expenditures for the CHS program, thereby excluding consideration for dental and patient/escort costs. The Work Group chose not to include travel costs[3] in the formula due to difficulties in obtaining accurate data on travel in time for the FY2001 distribution.

[2] ACCRA Cost of Living Index, Comparative Data for 308 Urban Areas, Vol. 33. No.3, published January 2001

[3] The Alaska representative asked to go on record in opposition to this decision.

The cost adjustment factor is constructed as follows:

Cost Factor = **.65**(Inpatient Cost) + **.35**(Outpatient Cost)

Where:

Inpatient Cost = cost of hospital day in referral location compared to national average.

Outpatient Cost = cost of doctor visit in referral location compared to national average.

The cost factor is determined by combining a percentage of the relative cost of each component. The weight should reflect the current national percentage of the contract health funds expended in each category (the percentages provided are estimates based on the FY99 distribution data). The Work Group also agreed that the cost factors selected are the CHS referral locations for the operating unit. Or if data in ACCRA was not available, the closest location to the OU in the ACCRA report was used.

Access to Hospitals Operated by IHS or Tribes

The Work Group also felt it was important to recognize that some operating units rely solely or more heavily on CHS funding for all inpatient care. The group had some difficulty clearly defining exactly what variables could be used in the formula to accurately describe this access.

After discussion the Work Group agreed that operating units without access to IHS or Tribal hospitals should receive an additional adjustment factor in this portion of the formula. This factor of 1.25 would be multiplied by the number of active users in the qualifying operating units.

The OUs will qualify for the 1.25 adjustment if they meet the following criteria:

- There is no IHS/Tribal hospital in the OU with an Average Daily Patient Load (ADPL) of 5 or more; and,

- The OU does not have an established referral pattern to an IHS/Tribal hospital. The established referral pattern means that more than 50% of inpatient admissions go to an IHS/Tribal hospital.

Several Work Group members felt that the adjustment should be more complex and take into account the full range of dependency on CHS or access to direct facilities. Virtually all Work Group members felt that this adjustment factor should be refined in future allocation methodologies to more fully reflect the complexities of the IHS delivery system. For the current year, however, the Work Group could not provide a more accurate adjustment factor that they felt was understandable and based on scientifically accurate and valid data.

Final Calculation of the New Formula

The user population, cost adjustment, and the access factor are multiplied together to obtain a numeric value for each OU. These values for each OU are added together for a total for the entire system. Each OU number is divided by the total to create a percentage of the total. This percentage is applied to the remaining resources (after subtracting the amounts for earmarks and inflation adjustments from the initial appropriation).

Effects of the Rescission

In the FY 2001 budget, there was a 0.22% rescission to balance the federal budget in accordance with P.L. 106-554. This 0.22% was taken against the entire recurring base of the agency. The work group recommends that the formula be calculated on the entire appropriation prior to the rescission. This means that after the formula is applied, each OU allotment will be reduced by 0.22% of each OU's recurring CHS base, which must result in a total reduction of $949,863.

Summary of the Distribution Plan

After the funding for earmarks is reserved from the appropriation the remaining CHS funding increases will be distributed as new funding. These funds will be distributed on a recurring basis. This formula is expressed mathematically as follows:

Inflation Funding = CHS Base for OU x 3.9% (OMB inflation rate, 2001)

New Formula Funding = Active Users for OU x Cost Factor x Access Factor (Converted to proportionate percentage)

(See Appendix E)

Process for Tribal Review of Data

Once the formula is approved for use, it is important that the accuracy of the data be verified by Areas and the Tribes on an annual basis. The WG recommends that the Tribes receive the opportunity to review data in the formula and make corrections prior to distribution of funds. The WG thinks it is also important to distribute the new funds in the first quarter of each fiscal year. If this formula is used for FY 2002 the only data that must be updated is active user data and the inflation rate. If the formula is going to be revised in any future year once it's approved, it should be done prior to the beginning of the fiscal year to ensure a distribution in the first quarter.

The following dates are submitted for consideration, to insure adequate time is allowed for tribal review of data for FY 2001 and in future years.

2001 Tribal Consultation Process

March 8-9	Tribal Consultation
March 12	Dr. Trujillo decision
March 13-25	Tribe Review Data
March 30	2001 Distribution

Future Year Allocations

July	Form WG, if necessary
August -September	Review formula, including cap on inflation
September-October	Tribes review data
10 days after apportionment	Distribute Funds

Suggestions for Future Refinements in the Formula

The formula presented for 2001 represent the best effort given available data and timeframe. The WG recommends refinements of the formula in future years. Some of the issues that have been identified for review are:

- Review the cap on inflation
- Seek verifiable data on patient and patient escort travel for inclusion in the formula and determine what cost index to use, including reasonable costs.
- Review and refine access to care factor.
- Representatives from all the Area be selected on an equal basis
- Review definition/designation of OUs
- Insure equal representation in future Work Groups

Questions and Answers

1. Why didn't the WG use the Level of Need Funded (LNF) formula?

The TWG and WG did discuss using the LNF formula. This could have been accomplished by subtracting the hospitals and clinics (H&C) appropriations from the LNF to determine the unmet need for CHS, and then allocating proportional share to all operating units. However, this idea was rejected for two reasons:

- The charge to the WG was to develop a formula that is independent of other formulas.

- While the LNF tribal consultation process has not yet been completed, it appears that consensus was forming to use the LNF formula only for the Indian Health Care Improvement Fund.

2. Why is health status not a factor in the CHS allocation formula?

Health status indicators are important for the Indian health system as a whole to help Congress understand the extraordinary needs for health care funding. The TWG believes that this additional funding for CHS is essential to improve the health status for American Indians and Alaska Natives in all IHS Areas. Specific measures of health status are not included in the allocation formula for the following reasons:

- Health status by itself is not an indicator of CHS need. Two tribes with similar health status with different delivery systems may vary widely in their CHS funding needs.

- The CHS distribution methodology is not a measurement of budgetary needs. The LNF process, which is designed to be a valid estimate of overall budgetary needs, includes CHS. LNF does fully factor in health status among Areas in the funding methodology.

- Health status measures based on mortality are not accurate at the operating unit level. The populations are so small that calculating rates of death due to specific diseases would be misleading and fluctuate wildly from year to year.

- Mortality statistics come from states. They often do a poor job of identifying AI/AN, which results in undercounting in some Areas.

- There is no tribe that believes its tribal members have good health status. Different tribes suffer from different types of health problems. Deciding how to weight health problems (i.e., which type of health status deficiency is most important) should be a matter of tribal sovereignty.

- Measures of health status used in the CHS formula should relate to costs borne by the CHS. Some high cost diagnoses are predominantly paid by alternate resources. For example, Medicaid pays for a high percentage of deliveries and neonatal intensive care, Medicare pays for dialysis, and CHEF pays for complicated injuries. Furthermore, special funding is available to some extent to address some of the health status disparities in AI/AN populations, including programs for injury prevention, tobacco cessation, mental health, substance abuse, and diabetes.

- Previous CHS formulas used Years of Productive Life Lost (YPLL), but this is not a good health status indicator to use in the distribution of IHS funds. It does not relate to the cost of treating illness, but rather reflects the cost of disease to society in terms of lost wages and taxes. Also, it assigns much greater weight

to disease that occurs in youth, which does not actually cost CHS more to treat than disease that occurs in elders.

- Research and better data on disease prevalence are needed to accurately select health status indicators that relate to the cost of CHS.

- Health status is meaningful in comparing the AI/AN population to the general U.S. population for justification of new funding, but less meaningful in allocation of funds within the IHS among Areas and Tribes.

3. Why was 1.25 chosen as the factor for OU's without hospitals?

The Work Group felt that "dependency" or access to care in IHS/Tribal facilities should be an important consideration in developing a formula for distribution of CHS funding. There is a wide diversity in how CHS resources are used and how OUs are organized. There was not a clear consensus of how this "access" or "dependency" was to be defined and no objective indicators could be found.

Despite this lack of empirical data the Work Group felt it was important to provide an adjustment for access to care in IHS/Tribal facilities. After some discussion, the somewhat subjective decision was reached to provide the 25% modifier to facilities not able to access IHS or tribal inpatient facilities.

4. Why was an Average Daily Patient Load (ADPL) of 5.0 chosen as a cut off in the "access to care" factor?

The Work Group examined services provided by very small hospitals and determined that very small hospitals did not offer a range of services that would substitute for CHS expenditures. Specifically, in the smaller hospitals, there are no or few deliveries, no anesthesiology services, and no surgeries. A total of fourteen (14) of forty-nine (49) IHS/Tribal hospitals were not considered "access to care" due to the limited scope of services provided. Furthermore, the limit of 5.0 ADPL is consistent with the threshold established in the IHS facility planning methodologies.

5. Why were ACCRA data utilized and not CHS fiscal intermediary (FI) data?

ACCRA is the most commonly recognized and used database to describe geographic differences in costs. Conversely, the FI data are not complete because some Tribal health data are not included. The FI data do not provide comparable unit costs across geographic areas. Furthermore, the expenditure data in the FI system have inconsistencies of provider rates obtained through contractual arrangements at locations throughout the country.

6. How was the 65/35 weight for the cost factor determined?

The Work Group based this weight upon the FY99 cost data from the F.I. Total inpatient and outpatient billed charges were compared, and the resulting percentages for inpatient and outpatient were determined to be 65% and 35%, respectively. These national averages were used consistently across OUs to weight the cost factor. Although the F.I. data do not include all tribes, they are expected to be representative of the system. There is significant variation between operating units in the utilization of CHS resources between inpatient and outpatient resources. Despite these shortcomings, the index does reflect a significant percentage of the cost variation experienced in the CHS program. Furthermore, data to reflect the actual conditions in each operating unit are not readily available, and is relatively insensitive to the changes in this ratio. Dental CHS costs, which reflect less than 3% of all CHS costs are not included.

7. Why were travel costs excluded from the relative cost adjustment in the 2001 formula?

Travel costs were excluded from the formula because the data available on CHS travel costs was incomplete. In addition, travel cost cannot be indexed for cost like other elements of the formula, and there are no valid sources for this index. This is because travel costs vary due to location, distance and mode of transportation, not in relationship to the unit cost of travel. For example, travel costs may be much higher because of long distances, not because it costs more per mile. A valid cost index for travel should compare relative cost per trip for patient and patient escort travel and no such index is available.

8. Why didn't the WG recommend taking the rescission "off the top" before distributing the $40 million increase?

Congress legislated a government-wide recission in P.L. 106-554. This rescission is a reduction to the entire IHS recurring budget (across the board). This means that the 0.22% must be applied to not only the $40 million increase, but also to the recurring CHS OU base of $389,922,579 that has already been distributed. The rescission rate must be applied to the recurring CHS base, as well as to the new CHS funding. The IHS should also avoid a "pay back" of funds already allocated to the local level. To accomplish this, the rescission should be deducted from each OU's increase after the formula is applied, but before funds are distributed. In this way, the $40 million is allocated and the 0.22% rescission is accurately applied to all CHS allocations.

APPENDIX A

CHARGE TO WORKGROUP

The charge to the Workgroup is to provide a formal written recommendation to the Director of Indian Health Services on a CHS distribution methodology that considers a variety of complex factors such as but not limited to: 1) Inflation, 2) separation of CHS from direct service formulas/methodologies; 3) CHS dependent environments; 4) utilization of CHS funding for provision of services provided at IHS facilities; 5) variables in cost allocations; and 6) access to health care providers and services. The Workgroup will consider options for forecasting resources and costs that are widely recognized in the health industry and Federal government and are also practical to apply. The workgroup will advise on means to measure available resources that are necessary to compute a CHS percentage that is equitable. Areas in consultation with tribes will have the authority to further develop distribution methodologies according to the I/T program needs.

WORKGROUP COMPOSITION

The Workgroup will be composed of tribal and IHS representatives and from selected from Area. Representative to the workgroup may be comprised from the Tribal Self-Governance Advisory Committee, the National Indian Health Board, the Indian Health Leadership Council, tribes and the IHS. A Federal and a tribal co-chair will be elected at the initial meeting. Indian organizations, other Federal agencies, and various institutions may be sought from time to time, with supplemental work by IHS staff.

LOGISTICS AND SUPPORT

The Workgroup will meet as necessary, with logistical support provided by IHS Headquarters. The budget authorized for the support of the Workgroup will be determined on a quarterly basis and travel expenses for the Workgroup for no less than three meetings will be authorized. Consultant services if needed will be funded as appropriate.

EXPECTED PRODUCTS

The CHS Allocation Workgroup is expected to complete its charge by February 28, 2001.

APPENDIX B

Mathematical Description of recommended formula:

$$\Delta CHS_{OU} = (CHS_{base} \times INFLATION_{omb}) + \left[\frac{(ACTIVE\ USERS_{OU} \times COST_{adj.} \times ACCESS_{dir.\ hosp.})}{\Sigma_{IHS}(ACTIVE\ USERS_{OU} \times COST_{adj.} \times ACCESS_{dir.\ hosp})} \right] \times APPROP._{remaining}$$

Where:

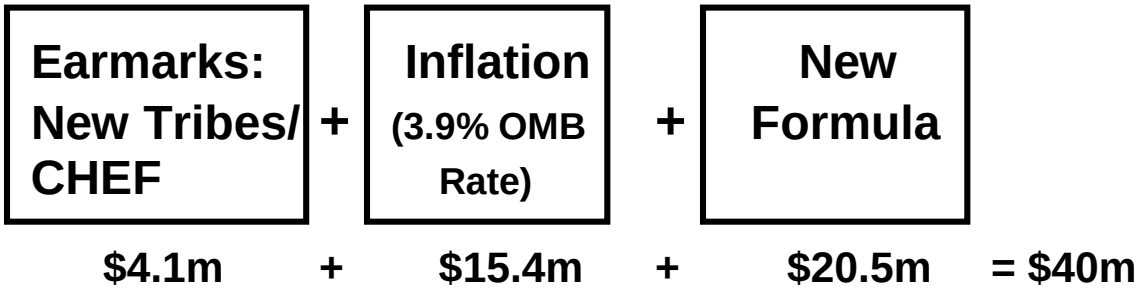
ΔCHS_{OU}	= the increase in CHS funds for each operating unit
CHS_{base}	= the base CHS recurring funds for each operating unit (excludes CHEF funds which are NR)
$INFLATION_{omb}$	= The inflation rate for medical programs as defined by the Office of Management and Budget
$ACTIVE\ USERS_{OU}$	= The most recently available number of active users for each operating unit that reside in a CHSDA
$COST_{adj.}$	= cost adjustment factor based on the ACCRA regional cost data
$ACCESS_{dir\ hosp.}$	= a “yes/no” variable which indicates whether an OU has access to an IHS funded hospital
$APPROP._{remaining}$	= the remaining portion of the CHS increase after funds for CHEF, New tribes, and inflation adjustments have been removed from the total new funding.

APPENDIX C

FY 2001 Estimated Distribution

$40,000,000	New CHS Funding
(140,000)	Ketchikan Indian Corporation agreement
(3,000,000)	CHEF increase
(1,000,000)	New Tribe Funding (ESTIMATED)
$35,860,000	Remaining to Distribute
$15,395,484	Distributed According to Inflation Funding
$20,464,516	Distributed With New Formula (remaining approp.)

Rescission is deducted after calculation but before funds are distributed.



APPENDIX D

CHS Allocation Work Group Members

Vern Donnell, Co-Chair, Pine Ridge Service Unit, IHS
Lydia Hubbard-Pourier, Co-Chair, Navajo Health Systems Corp.
Everett Enno, NIHB, Aberdeen Area Indian Health Board
Don Kashevaroff, Alaska Native Tribal Health Consortium
Linda Cortez, Ysleta Del Sur Tribe
Deanna Bauman, Oneida Nation of Wisconsin
Gregg Duffek, Stockbridge Munsee Tribe
Kathy Annette, MD, Bemidji Area IHS
Anna Sorrel, Confederated Salish and Kootenai Tribe
Garfield Little Light, Billings Area IHS
Jim Crouch, California Rural Indian Health Board
    Alternate: Rachel Joseph, Lone Pine Reservation
Brenda Commander, Houlton Band of Maliseet Tribe
    Alternate: Tom John, Brenda Shore-Fuller, United South & Eastern Tribes
Douglas Peter, MD, IHS Chief Medical Officers, Navajo Area
Mickey Peercy, Oklahoma Area Tribal Health Board
Wanda Stone, Kaw Nation, Tribal Self-Governance Advisory Committee
Gloria Holder, IHS Contract Health Officers
Mariddie Craig, White Mountain Apache Tribal Council
    Alternate: Judy Cranford, Paiute Indian Tribe of Utah
Eric Metcalf, Coquille Tribal Health Center
Julia Davis, National Indian Health Board
Richard Ramirez, Tohono O'Odham

CHS Technical Sub-Work Group Members

Vern Donnell, Co-Chair, Pine Ridge Service Unit IHS
Flora Odegaard, Aberdeen Area IHS
Dave Mather, Alaska Tribal Health Compact
Maria Clark, Albuquerque Area IHS
Gregg Duffek, Stockbridge Munsee Tribe
Garfield Little Light, Billings Area IHS
Tom John, United South & Eastern Tribes
Gloria Holder, Contract Health Officer Oklahoma Area IHS
Dan Cameron, Oklahoma Area IHS
Melanie Knight, Cherokee Nation
Mim Dixon, Cherokee Nation
Elvin Willie, Schurz Service Unit, IHS
Ed Fox, Northwest Portland Area IHB
Clayton Old Elk, IHS Headquarters

HQ Support

Craig Vanderwagen, MD	Carol Littlefield	John Yao, MD
Jim Bresette	Brenda Jeanotte	Linda Querec, Debra Heller

APPENDIX E

SPREAD SHEET ON GEOGRAPHICAL AREAS AND DISTRIBUTION

I. INFLATION PORTION OF PROPOSED CHS DISTRIBUTION

II. REGIONAL COST DATA & ACCESS TO IHS/TRIBAL HOSPITAL

III. CHS DISTRIBUTION RESULTS